SERFF Tracking Number:	*NDPL-125671419*	*State:*	*Arkansas*
Filing Company:	*Indianapolis Life Insurance Company*	*State Tracking Number:*	*39235*
Company Tracking Number:	*3CAIG08*		
TOI:	*L04I Individual Life - Term*	*Sub-TOI:*	*L04I.103 Renewable - Single Life - Fixed/Indeterminate Premium*
Product Name:	*Children's Insurance Rider*		
Project Name/Number:	*3CIAG08/3CIAG08*		

Filing at a Glance

Company: Indianapolis Life Insurance Company

Product Name: Children's Insurance Rider	SERFF Tr Num: NDPL-125671419	State: ArkansasLH
TOI: L04I Individual Life - Term	SERFF Status: Closed	State Tr Num: 39235
Sub-TOI: L04I.103 Renewable - Single Life - Fixed/Indeterminate Premium	Co Tr Num: 3CAIG08	State Status: Approved-Closed
Filing Type: Form	Co Status:	Reviewer(s): Linda Bird
	Authors: Angela Vennall, Dana Kelly	Disposition Date: 06/11/2008
	Date Submitted: 06/09/2008	Disposition Status: Approved
Implementation Date Requested:		Implementation Date:

State Filing Description:

General Information

Project Name: 3CIAG08	Status of Filing in Domicile: Authorized
Project Number: 3CIAG08	Date Approved in Domicile: 06/06/2008
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 06/11/2008	
State Status Changed: 06/11/2008	Deemer Date:
Corresponding Filing Tracking Number:	

Filing Description:

Enclosed for your approval is our Children’s Insurance Rider, Form 3CIAG08.

This individual life rider form has been revised to comply with the 2001 Commissioner’s Standard Ordinary Mortality Table regulations.

SERFF Tracking Number:	*NDPL-125671419*	*State:*	*Arkansas*
Filing Company:	*Indianapolis Life Insurance Company*	*State Tracking Number:*	*39235*
Company Tracking Number:	*3CAIG08*		
TOI:	*L04I Individual Life - Term*	*Sub-TOI:*	*L04I.103 Renewable - Single Life - Fixed/Indeterminate Premium*
Product Name:	*Children's Insurance Rider*		
Project Name/Number:	*3CIAG08/3CIAG08*		

This form is an optional benefit rider which is designed to provide Term Insurance coverage on each of the Insured's eligible children. The Term Insurance expires when the Insured Child reaches the age of 25. This Rider does not generate cash values.

This form replaces form number 31745H02, approved by your Department on September 3, 2002.

This Rider is intended for the general market and will be individually solicited through licensed agents. The issue ages are: 18-55, Age Nearest Birthday, for the primary insured and 15 days to 17 years for the child.

A sample date page is enclosed to demonstrate how the benefit description will be shown.

The Illustration Regulation does not apply to this form and it will not be marketed with an illustration.

This form is written in simplified and readable language and does not contain any unusual or possibly controversial items from normal company or industry standards.

This form has been produced from our Automated Policy Assembly Laser system and is in final print.

You may direct any questions or comments regarding this submission to me at (800) 457-3557, ext. 6747 or e-mail me at dana.kelly@avivausa.com.

Company and Contact

Filing Contact Information

Dana Kelly, Product Compliance Specialist	dana.kelly@avivausa.com	
Indianapolis Life Insurance Company	(317) 927-6747 [Phone]	
Indianapolis, IN 46240	(317) 927-6510[FAX]	

Filing Company Information

Indianapolis Life Insurance Company	CoCode: 64645	State of Domicile: Indiana
9200 Keystone Crossing	Group Code: 1225	Company Type:
Suite 800		

SERFF Tracking Number:	*NDPL-125671419*	*State:*	*Arkansas*
Filing Company:	*Indianapolis Life Insurance Company*	*State Tracking Number:*	*39235*
Company Tracking Number:	*3CAIG08*		
TOI:	*L04I Individual Life - Term*	*Sub-TOI:*	*L04I.103 Renewable - Single Life - Fixed/Indeterminate Premium*
Product Name:	*Children's Insurance Rider*		
Project Name/Number:	*3CIAG08/3CIAG08*		

Indianapolis, IN 46240
(317) 927-6476 ext. [Phone]

Group Name:
FEIN Number: 35-0413330

State ID Number:

SERFF Tracking Number:	*NDPL-125671419*	*State:*	*Arkansas*
Filing Company:	*Indianapolis Life Insurance Company*	*State Tracking Number:*	*39235*
Company Tracking Number:	*3CAIG08*		
TOI:	*L04I Individual Life - Term*	*Sub-TOI:*	*L04I.103 Renewable - Single Life - Fixed/Indeterminate Premium*
Product Name:	*Children's Insurance Rider*		
Project Name/Number:	*3CIAG08/3CIAG08*		

Filing Fees

Fee Required?	Yes
Fee Amount:	$35.00
Retaliatory?	Yes
Fee Explanation:	1 Rider x $35.00 = $35.00
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Indianapolis Life Insurance Company	$35.00	06/09/2008	20735743

SERFF Tracking Number:	*NDPL-125671419*	*State:*	*Arkansas*
Filing Company:	*Indianapolis Life Insurance Company*	*State Tracking Number:*	*39235*
Company Tracking Number:	*3CAIG08*		
TOI:	*L04I Individual Life - Term*	*Sub-TOI:*	*L04I.103 Renewable - Single Life - Fixed/Indeterminate Premium*
Product Name:	*Children's Insurance Rider*		
Project Name/Number:	*3CIAG08/3CIAG08*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Linda Bird	06/11/2008	06/11/2008

SERFF Tracking Number:	*NDPL-125671419*	*State:*	*Arkansas*
Filing Company:	*Indianapolis Life Insurance Company*	*State Tracking Number:*	*39235*
Company Tracking Number:	*3CAIG08*		
TOI:	*L04I Individual Life - Term*	*Sub-TOI:*	*L04I.103 Renewable - Single Life - Fixed/Indeterminate Premium*
Product Name:	*Children's Insurance Rider*		
Project Name/Number:	*3CIAG08/3CIAG08*		

Disposition

Disposition Date: 06/11/2008
Implementation Date:
Status: Approved
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*NDPL-125671419*	*State:*	*Arkansas*
Filing Company:	*Indianapolis Life Insurance Company*	*State Tracking Number:*	*39235*
Company Tracking Number:	*3CAIG08*		
TOI:	*L04I Individual Life - Term*	*Sub-TOI:*	*L04I.103 Renewable - Single Life - Fixed/Indeterminate Premium*
Product Name:	*Children's Insurance Rider*		
Project Name/Number:	*3CIAG08/3CIAG08*		

Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice		Yes
Supporting Document	Application		Yes
Supporting Document	Life & Annuity - Acturial Memo		No
Supporting Document	CI Sample Data Page - ILICo		Yes
Form	Children's Insurance Rider		Yes

SERFF Tracking Number:	*NDPL-125671419*	*State:*	*Arkansas*
Filing Company:	*Indianapolis Life Insurance Company*	*State Tracking Number:*	*39235*
Company Tracking Number:	*3CAIG08*		
TOI:	*L04I Individual Life - Term*	*Sub-TOI:*	*L04I.103 Renewable - Single Life - Fixed/Indeterminate Premium*
Product Name:	*Children's Insurance Rider*		
Project Name/Number:	*3CIAG08/3CIAG08*		

Form Schedule

Lead Form Number: 3CIAG08

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	Form 3CIAG08	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Children's Insurance Rider	Initial		50	3CIAG08.PDF

INDIANAPOLIS LIFE

An AMERUS Company

INDIANAPOLIS LIFE INSURANCE COMPANY

Home Office: 9200 Keystone Crossing, Suite 800, Indianapolis, IN 46240
Administrative Office: 611 Fifth Avenue, Des Moines, IA 50309
1-800-428-7031

CHILDREN'S INSURANCE RIDER

Attached to and made a part of this policy

We agree to provide the term insurance benefits of this rider upon receipt of due proof of the death of an insured child. These benefits are subject to the provisions, terms and conditions of this rider and the policy to which it is attached.

Insurance on the life of each insured child will be term insurance for the amount shown on the Policy Data Page. This insurance expires on the child's twenty-fifth birthday or on this rider's expiry date, whichever is earlier.

INSURED CHILD

An insured child under this rider is any child at least fifteen days old who is:

a) any child, stepchild or legally adopted child of the insured who is named in the application for this rider and has not reached age eighteen on the date of the application;
b) any child born to the insured after the rider date; and
c) any child legally adopted by the insured after the rider date.

BENEFICIARY PROVISION

During the insured's lifetime, the beneficiary of this rider shall be the owner under the policy unless specified otherwise in the application or changed as provided in the policy and this rider. Written notice of any beneficiary change for any insured child must be filed with us while the insured child is living.

PREMIUMS

The additional premiums for this rider are payable at the same time and in the same manner as premiums for the policy. Premiums for this rider are not payable after this rider has terminated. This rider is issued in consideration of the application received and the payment of the premiums as shown on the Policy Data Page.

REINSTATEMENT

You may reinstate this rider at any time within five years after the end of the grace period, provided the policy to which it is attached is also reinstated.

The requirements for reinstatement are:

a) submit an application for reinstatement;
b) submit evidence of insurability satisfactory to us for each insured child to be reinstated; and
c) pay all past due premiums with interest at 6.00% annually from their due dates.

Reinstatement of this rider will be effective on the date of reinstatement of the policy. The incontestability provision will apply from the date of reinstatement for each insured child. If the rider has been in force for two years during the insured child's lifetime, it will be contestable only as to statements made in the reinstatement application.

CONVERSION PRIVILEGE

When any term insurance on the life of an insured child expires, it may be converted to a new policy without evidence of insurability. The amount of insurance for a new policy on an insured child may not exceed five times the amount expiring under this rider and may not be less than the minimum for the plan selected. The effective date of the new policy will be the date the term insurance expires.

THE NEW POLICY

The requirements for conversion are:

a) this rider must be in force on the date the coverage for an insured child expires;
b) you must submit an application for the new policy and pay the first premium during the lifetime of the insured child and within 31 days after the coverage for the insured child expires; and
c) the new policy may be any single life permanent plan of insurance which qualifies under our rules in effect on the policy date of the new policy.

Premiums and values for the new policy will be based on:

a) a rate class most comparable to the insured child's rate class under this rider;
b) rates in effect on the date of exchange; and
c) the insured child's attained age nearest birthday on the date of conversion.

DEATH DURING CONVERSION PERIOD

If an insured child having the right to convert should die within the 31 day conversion period, without having exercised the right, we will pay a death benefit equal to the amount of term insurance expiring on the child's life. This benefit will be paid to the applicable beneficiary as of the date of expiry, upon receipt of satisfactory proof of the death.

PAID-UP TERM INSURANCE BENEFIT

If the insured should die while this rider is in force on a premium paying basis, any term insurance then in force under this rider will continue as a paid up term insurance until the term insurance would normally have expired on each insured child.

This paid-up term insurance may be surrendered for its cash value upon your written request. The cash value of the paid-up term insurance within 30 days after a policy anniversary will not be less than the value on the anniversary. The cash value will be the net single premium of all future guaranteed benefits at the attained age of each insured child covered as of the date of surrender, assuming the following:

a) the 2001 Commissioner's Standard Ordinary Mortality Table;
b) continuous functions;
c) interest at 4% per annum; and
d) attained age nearest birthday.

Information regarding the cash value will be furnished by us upon request.

INCONTESTABILITY

Insurance on the life on an insured child will not be contestable after it has been in force for two years during the lifetime of the insured child except for non-payment of premiums.

SUICIDE

If the insured or an insured child commits suicide, while sane or insane, during the first two years this rider is in force, our liability will be limited to the amount of premiums paid, and the rider will then terminate.

MISSTATEMENT OF AGE

If the birth date of an insured child has been misstated, all rights and liabilities with respect to the child will be in accordance with the correct birth date and age of the child.

TERMINATION

This rider will terminate on the earliest of the following dates and events:

a) if any premium for this rider or policy remains unpaid at the end of its grace period;
b) when the policy is exchanged for another policy, matures, becomes paid-up in any manner or terminates for any reason other than death of the insured;
c) our receipt of your written request for termination of this rider; and
d) the expiry date of the rider as shown on the Policy Data Page or endorsement.

EFFECTIVE DATE

The effective date of this rider will be the policy date unless a later effective date is shown on the Policy Data Page or endorsement.

Christopher J. Littlefield
Secretary

SERFF Tracking Number:	*NDPL-125671419*	*State:*	*Arkansas*
Filing Company:	*Indianapolis Life Insurance Company*	*State Tracking Number:*	*39235*
Company Tracking Number:	*3CAIG08*		
TOI:	*L04I Individual Life - Term*	*Sub-TOI:*	*L04I.103 Renewable - Single Life - Fixed/Indeterminate Premium*
Product Name:	*Children's Insurance Rider*		
Project Name/Number:	*3CIAG08/3CIAG08*		

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number:	*NDPL-125671419*	*State:*	*Arkansas*
Filing Company:	*Indianapolis Life Insurance Company*	*State Tracking Number:*	*39235*
Company Tracking Number:	*3CAIG08*		
TOI:	*L04I Individual Life - Term*	*Sub-TOI:*	*L04I.103 Renewable - Single Life - Fixed/Indeterminate Premium*
Product Name:	*Children's Insurance Rider*		
Project Name/Number:	*3CIAG08/3CIAG08*		

Supporting Document Schedules

Review Status:

Satisfied -Name: Certification/Notice 05/29/2008

Comments:

Attachments:

AR3703.pdf
AR3705.pdf
ARreg19_ILICo.pdf
ARreg49_ILICo.pdf
AR RDCRT - CI ILCIo.pdf

Review Status:

Satisfied -Name: Application 05/29/2008

Comments:

Copies of the Application and TeleApp Application used to apply for this rider are attached. Form 14530 2/07 and Form 15094 2/07. They were approved by your Department on 8/28/06.

Attachments:

14530_2-07.pdf
15094_2-07.pdf

Review Status:

Satisfied -Name: CI Sample Data Page - ILICo 06/02/2008

Comments:

CI Sample Data Page is attached.

Attachment:

CI Sample Data Page - 10 Year Plan.pdf

INDIANAPOLIS LIFE

An AMERUS Company

INDIANAPOLIS LIFE INSURANCE COMPANY

Home Office: 9200 Keystone Crossing, Suite 800, Indianapolis, IN 46240
Administrative Office: 611 Fifth Avenue, Des Moines, IA 50309

APPENDIX A

LIMITATIONS AND EXCLUSIONS UNDER THE ARKANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of this state who purchase life insurance, annuities or health and accident insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association"). The purpose of this Guaranty Association is to assure that policy and contract owners will be protected, within certain limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of policy owners who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by the member insurers through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting insurance companies that are well managed and financially stable.

DISCLAIMER

The Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association") may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions and require continued residency in this state. You should not rely on coverage by the Guaranty Association in purchasing an insurance policy or contract.

Coverage is NOT provided for your policy or contract or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract.

Insurance companies or their agents are required by law to provide you with this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce you to purchase any kind of insurance policy.

The Arkansas Life and Health Insurance Guaranty Association
c/o The Liquidation Division
1023 West Capital
Little Rock, Arkansas 72201

Arkansas Insurance Department
1200 West Third Street
Little Rock, Arkansas 72201-1904

The state law that provides for this safety-net is called the Arkansas Life and Health Insurance Guaranty Association Act ("Act"). Below is a brief summary of the Act's coverages, exclusions and limits. This summary does not cover all provisions of the Act; nor does it in any way change anyone's rights or obligations under the Act or the rights or obligations of the Guaranty Association.

COVERAGE

Generally, individuals will be protected by the Guaranty Association if they live in this state and hold a life, annuity or health insurance contract or policy, or if they are insured under a group insurance contract issued by a member insurer. The beneficiaries, payees or assignees of policy or contract owners are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons owning such policies are NOT protected by the Guaranty Association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- The insurer was not authorized to do business in this state;
- Their policy or contract was issued by a nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy or contract owner is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does NOT provide coverage for:

- Any policy or contract or portion thereof which is not guaranteed by the insurer or for which the owner has assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed an average rate;
- Dividends and voting rights and experience rating credits;
- Credits given in connection with the administration of a policy by a group contract holder;
- Employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts (which give rights to group contractholders, not individuals);
- Unallocated annuity contracts issued to/in connection with benefit plans protected under Federal Pension Benefit Corporation ("FPBC")(whether the FPBC is yet liable or not);
- Portions of an unallocated annuity contract not owned by a benefit plan or a government lottery (unless the owner is a resident) or issued to a collective investment trust or similar pooled fund offered by a bank or other financial institution);
- Portions of a policy or contract to the extent assessments required by law for the Guaranty Association are preempted by State or Federal law;
- Obligations that do not arise under the policy or contract, including claims based on marketing materials or side letters, riders, or other documents which do not meet filing requirements, or claims for policy misrepresentations, or extra-contractual or penalty claims;
- Contractual agreements establishing the member insurer's obligations to provide book value accounting guarantees for defined contribution benefit plan participants (by reference to a portfolio of assets owned by a nonaffiliate benefit plan or its trustees).

LIMITS ON AMOUNT OF COVERAGE

The Act also limits the amount the Guaranty Association is obligated to cover: The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Guaranty Association will pay a maximum of $300,000 - no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within this overall $300,000 limit, the Association will not pay more than $300,000 in health insurance benefits, $300,000 in present value of annuity benefits, or $300,000 in life insurance death benefits or net cash surrender values - again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages. There is a $1,000,000 limit with respect to any contract holder for unallocated annuity benefits, irrespective of the number of contracts held by the contract holder. These are limitations for which the Guaranty Association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer.

INDIANAPOLIS LIFE

An AMERUS Company

INDIANAPOLIS LIFE INSURANCE COMPANY
Home Office: 9200 Keystone Crossing, Suite 800, Indianapolis, IN 46240
Administrative Office: 611 Fifth Avenue, Des Moines, IA 50309

TO: Indianapolis Life Policyowner

FROM: Indianapolis Life Insurance Company

Bulletin number 6-87, Act 197 of 1987 from the Arkansas Department of Insurance requires effective January 1, 1988 that we provide you with information on our Company, our Agent servicing your policy and on the Arkansas Department of Insurance. Listed below are the names and addresses in the event you would like to contact one of us for more information on your policy.

Indianapolis Life Insurance Company
Home Office: 9200 Keystone Crossing, Suite 800, Indianapolis, IN 46240
Administrative Office: 611 Fifth Avenue, Des Moines, IA 50309

Telephone: 1-800-428-7031

Agent Name: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
Agent Address: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

Agent Telephone: XXXXXXXXXXXXXX

Arkansas Insurance Department
Consumer Services Division
1200 West Third Street
Little Rock, AR 72201-1904

Telephone: 1-800-852-5494

Arkansas Certification
Regulation 19

I certify that this submission meets the provisions of Regulation 19, Section 10B, as well as all applicable statutes, regulations, and bulletins of the State of Arkansas.

Indianapolis Life Insurance Company

Chris Guttin, ASA
Vice-President-Product Operations

06/09/2008
Date

Form Numbers

3CIAG08 – Children's Insurance Rider

Regulation 19

Arkansas Certification
Regulation 49

We have reviewed Regulation 49 against the issue procedures of the Company and certify that we are in compliance with the requirements of Regulation 49.

Indianapolis Life Insurance Company

Chris Guttin, ASA
Vice-President-Product Operations

06/09/2008
Date

Form Numbers

Form 3CIAG08 – Children's Insurance Rider

Regulation 49

AR

ARKANSAS READABILITY CERTIFICATION

This is to certify that the attached, Form 3CIAG08 – Children's Insurance Rider, has achieved a Flesch Reading Ease Score of 50.0 and complies with the requirements of Arkansas Statute Ann. 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

Indianapolis Life Insurance Company

Chris Guttin
ASA / Vice President-Product Operations

June 9, 2008
Date

RD/CRT/AR

☐ AMERUS Life ☐ INDIANAPOLIS LIFE An AMERUS Company

Application for Insurance

AmerUs Life Insurance Company
Home Office: Des Moines, IA
Mailing Address:
P.O. Box 1555
Des Moines, IA 50306-1555
Fax: 1-800/531-0038

Indianapolis Life Insurance Company
Home Office: Indianapolis, IN
Mailing Address:
P. O. Box 14590
Des Moines, IA 50306-3590
Fax: 1-888/329-1329

Please check appropriate company. ONE BOX MUST BE CHECKED.
(In this application, "Company" refers to the insurance company whose name is checked above.)

APPLICANT INFORMATION

1. PROPOSED INSURED

Name (First, Middle, Last) _____ Is Insured also the Owner? ☐ Yes ☐ No

Address _____ E-Mail: _____

City _____ Home Ph. (_____) _____ Bus. Ph. (_____) _____

State _____ Zip _____ Gender ☐ M ☐ F Maiden Name _____

Birth Date _____ Birth State _____ Social Security Number _____

Marital Status ☐ Married ☐ Single ☐ Divorced or Separated ☐ Widow or Widower U.S. Citizen? ☐ Yes ☐ No Permanent Resident? ☐ Yes ☐ No

Driver's License # _____ State _____ Issue Date _____ Expiry Date _____

Or, if you do not have a driver's license, other government issued photo ID: Document Type _____

Document # _____ Where Issued _____ Issue Date _____ Expiry Date _____

Employer _____ How Long? _____ Occupation/Duties _____

Annual earned income $_____ Annual unearned income $_____ Net worth $_____

If multiple life product, (2nd app required for multiple life)

Joint Insured Names: (1st): _____ (2nd): _____

2. OWNER (If different from Proposed Insured) ☐ Individual ☐ Business ☐ Trust (date of trust) _____

Name (Owner, Business or Trustee) _____ Birth Date _____

If trust, name of trust _____

Address _____ City _____ State _____ Zip _____

Relationship to Proposed Insured _____ Social Security # or Taxpayer ID # _____

Owner's or Trustee's personal driver's license # or other government issued photo ID document, or corporate license:

Document Type _____ Document # _____ Where Issued _____ Issue Date _____ Expiry Date _____

Contingent Owner (If none specified, policy provisions will apply.) _____

Driver's License # or other government issued photo ID document:

Document Type _____ Document # _____ Where Issued _____ Issue Date _____ Expiry Date _____

Mail notices to ☐ Insured ☐ Owner ☐ Other (specify) _____

Other Notice Address _____ City _____ State _____ Zip _____

Tax Qualification Type

☐ Qualified Plan:
Type: ☐ Profit Sharing Plan
☐ 401(k)
☐ 412(i)
☐ Other Defined Benefit

☐ Non-Qualified Plan:
Type: ☐ Welfare Benefit Plan:
☐ single employer
☐ multiple employer
☐ VEBA
☐ Deferred Comp
☐ Split Dollar
☐ Executive Bonus
☐ Other _____

☐ Neither

3. PRIMARY BENEFICIARY(IES) - Applies to primary insured only. (If trust, complete name and date of trust.)
(If necessary, use an additional page for additional details, **signature of owner & date.)**

Print Full Name	Birth Date	Relationship	Percentage	Social Security # or Taxpayer ID #

4. CONTINGENT BENEFICIARY(IES)

Print Full Name	Birth Date	Relationship	Percentage	Social Security # or Taxpayer ID #

POLICY INFORMATION

5. PRIMARY INSURED ☐ Nonsmoker/Nontobacco ☐ Smoker/Tobacco

Base Plan _____ Amt. of Ins. $ _____

Additional Coverage _____ Amt. of Ins. $ _____ Premium $ _____

Additional Coverage _____ Amt. of Ins. $ _____ Premium $ _____

Riders (Complete Supplemental Application if applicable)

☐ Waiver Type _____ ☐ Other Riders (Type/Amount): _____

☐ Spouse Rider $_____ ☐ Child Rider $_____ _____

6. UL Death Benefit Option: ☐ Level ☐ Increasing ☐ Death Benefit Return of Premium Rider

Premium Direction/Interest Crediting Strategy: 1 Year Point-to-Point_____% 2 Year Point-to-Point_____% 1 Year Monthly Average_____%

1 Year Monthly Cap_____% 1 Year Average Multiple Index_____% 5 Year Fixed Term_____% 1 Year Fixed Term_____% _____%

Levelized Strategy Transfer ☐ Yes ☐ No

7. WHOLE LIFE APL (If applicable) ☐ Yes ☐ No Direct Recognition (if available) ☐ Yes ☐ No

PREMIUM INFORMATION

8. PREMIUM Planned Premium $_____ Additional Premium (Lump Sum) $ _____

Billing Frequency ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ PAC (Complete Authorization) ☐ Other _____

☐ Govt. Allotment (if available) ☐ Group Bill Group Bill #_____

Has the premium for the policy applied for been given to the agent? ☐ Yes ☐ No Amount $ _____

How Paid? ☐ Check ☐ Other (specify)_____

Additional Policy Specifications

Policy Date (optional)_____ Other _____

9. Are you financing or refinancing a mortgage and/or a home equity loan or contemplating the use of any kind of mortgage financing strategy in connection with the purchase of or the payment of premiums on the life insurance policy? . . . . . ☐ Yes ☐ No
(If yes, please review and acknowledge by signing the Mortgage Financing Disclosure Statement.)

10. Will you borrow money to pay the premiums for this policy or have someone else pay these premiums for you, in return for you assigning part of or all of the policy values to someone else? ☐ Yes ☐ No (If yes, please review and acknowledge by signing the Premium Financing Applicant Acknowledgement and Disclosure Statement.)

NON-MEDICAL INFORMATION

11. INSURANCE IN FORCE ON PROPOSED INSURED

a. Are any life insurance or annuity contracts in force? . . . . . ☐ Yes ☐ No
If yes, complete section below. (Attach separate sheet if necessary)

Company	Amount	WP ?	Personal/Business	Year Issued	Replacing ?	Amount ADB

b. Will any annuity or life insurance presently or recently inforce be replaced or changed by this policy applied for? . . . . . ☐ Yes ☐ No

c. Have you ever been declined, rated, or had coverage modified or withdrawn, or reinstatement declined by any insurance company? ☐ Yes ☐ No

d. Within the last year, has any other life, health or long term care insurance been issued or applied for, or is any to be applied for? . . ☐ Yes ☐ No

12. OTHER NON-MEDICAL INFORMATION

a. Do you use any form of tobacco or nicotine based products? . . . . . ☐ Yes ☐ No
If no, have you used any form of tobacco or nicotine based products in the last 5 years? . . . . . ☐ Yes ☐ No
If yes, when did you last use tobacco or nicotine based products? _____ Type_____ Quantity_____

b. Have you engaged in the last 3 years, or do you intend within the next 12 months to engage:
1. In any aviation activity other than as a passenger? . . . . . ☐ Yes ☐ No
2. In ballooning, gliding, boat or vehicle racing, mountain or rock climbing, parachuting, sky diving, underwater diving or any other hazardous sport or activity? . . . . . ☐ Yes ☐ No

c. Within the last 5 years, have you filed for bankruptcy (personal or business)? . . . . . ☐ Yes ☐ No

d. Within the last 5 years, have you been charged with reckless driving, driving under the influence of alcohol or drugs, or 2 or more moving violations, or had your driver's license revoked or suspended, or received a warning letter? . . . . . ☐ Yes ☐ No

e. Have you been arrested for an illegal activity, acquired a criminal record, or are you currently on probation, parole, or under investigation? ☐ Yes ☐ No

f. Are you a member of or do you contemplate joining one of the Armed Forces or an active or reserve military unit? . . . . . ☐ Yes ☐ No

g. Have you in the past 2 years traveled or do you intend to travel or live outside the United States or Canada? . . . . . ☐ Yes ☐ No

h. Is any proposed insured, owner or beneficiary a resident or citizen of or an entity organized under the laws of a country other than the U.S.? ☐ Yes ☐ No

i. Do you intend to sell or transfer all or any portion of this policy to another person, any group of investors or other entity? . . . . . ☐ Yes ☐ No

Give complete details of any **YES** answers to questions 11 and 12. (If necessary, use an additional page for additional details, **signed by the applicant and dated.)** _____

_____

13. PHYSICIAN INFORMATION

a. Name, address and phone # of your doctor(s) or health care provider(s): _____

_____

b. When did you last consult a doctor and why? _____

_____

c. What medication(s) (prescribed or over the counter) are you now taking? (If none, so state) _____

_____

MEDICAL INFORMATION If medical exam is required, questions 14-17 do not need to be completed.

14. PROPOSED INSURED

a. Height in shoes _____ feet _____ inches Weight in clothes _____ pounds

b. Have you gained or lost more than 10 pounds in the last year? . . . . . ☐ Yes ☐ No

c. Are you now under observation or treatment? . . . . . ☐ Yes ☐ No

d. Have you ever been diagnosed by a medical professional as having or been treated for AIDS or ARC (AIDS-related complex)? . . ☐ Yes ☐ No

e. Have you ever tested positive for antibodies to the AIDS Human T-Cell Lymphotropic (HIV) virus? . . . . . ☐ Yes ☐ No

f. Have you ever requested or received a benefit, military deferment, discharge or rejection, payment or pension because of a disability, injury, or sickness? . . . . . ☐ Yes ☐ No

15. HAVE YOU EVER HAD OR HAVE SYMPTOMS OF OR BEEN TREATED FOR:

a. Disease of the heart or circulatory system, including high blood pressure, heart attack, coronary artery disease, or chest pain? . . . ☐ Yes ☐ No

b. Heart murmur, rhythm abnormality, heart catheterization, echocardiogram or an exercise treadmill test? . . . . . ☐ Yes ☐ No

c. Cancer, tumors, lymphoma, leukemia, or any growths, lesions, polyps? . . . . . ☐ Yes ☐ No

d. Diabetes, thyroid, glandular or endocrinal disorder? . . . . . ☐ Yes ☐ No

e. Respiratory disorders including asthma, chronic bronchitis, emphysema, pneumonia, shortness of breath, or abnormal chest x-ray? ☐ Yes ☐ No

f. Disorder of the stomach, liver, pancreas or intestinal tract, including ulcerative colitis, Crohn's disease, or cirrhosis? . . . . . ☐ Yes ☐ No

g. Disorder of the kidneys, prostate, bladder, reproductive organs, sexually transmitted diseases, sugar, albumin or blood in urine? . . ☐ Yes ☐ No

h. Stroke, transient ischemic attack (TIA), Parkinson's, multiple sclerosis, seizures, epilepsy, chronic headaches, memory changes or fainting? . . . . . ☐ Yes ☐ No

i. Anxiety, depression, attempted suicide, attention deficit disorder or psychosis, mental or nervous system disorder? . . . . . ☐ Yes ☐ No

j. Anemia, hepatitis, or any blood disorder? . . . . . ☐ Yes ☐ No

k. Chronic back pain, arthritis, loss of limb, paralysis, muscle weakness or disease? . . . . . ☐ Yes ☐ No

16. WITHIN THE LAST FIVE YEARS, OTHER THAN AS NOTED ABOVE, HAVE YOU:

a. Seen a doctor, health care provider, counselor, therapist, or had any illness, injury, surgery, diagnostic test or treatment, or been advised to have any diagnostic test, surgery or treatment not yet completed? . . . . . ☐ Yes ☐ No

b. Been a patient of a clinic or hospital emergency room, or had any diagnostic test that was not normal? . . . . . ☐ Yes ☐ No

c. Used any drug, narcotic or controlled substance not prescribed by a physician, or been arrested, counseled, treated, or participated in a support group because of alcohol, controlled substance or drug use? . . . . . ☐ Yes ☐ No

d. Do you currently use alcoholic beverages? . . . . . ☐ Yes ☐ No
If yes, what is the average number of drinks per day? ☐ 2 or less ☐ 3-5 ☐ 6 or more.

17. FAMILY HISTORY

a. Is there a family history of diabetes, cancer, heart disease, mental illness, or any hereditary disorders? . . . . . ☐ Yes ☐ No

b. Family information (natural parents, brothers, sisters):

Family Member	Age if Living	Age at Death	Cause of Death
Father			
Brother(s)			

Family Member	Age if Living	Age at Death	Cause of Death
Mother			
Sister(s)			

Give complete details of any **YES** answers to questions 14 through 17. (If necessary, use an additional page for additional details, **signed by the applicant & dated.)**

Question Number	Date	Details, Include Diagnosis, Treatment, Duration, Result	Name, Address and Phone Number of Doctor / Medical Facility

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance may be guilty of a crime and subject to fines and confinement in prison, depending on state law.

TAXPAYER IDENTIFICATION

Instructions (Section references are to the Internal Revenue Code.)

Use this form to report the taxpayer identification number (TIN) of the **policy owner.**

Payors must generally withhold a specified percentage of taxable interest, dividend, and certain other payments if you fail to furnish payors with the correct taxpayer identification number (this is referred to as backup withholding). For most individual taxpayers, the taxpayer identification number is the social security number.

To prevent backup withholding on these payments, be sure to notify payors of the correct taxpayer identification number and properly certify that you are not subject to backup withholding under Section 3406(a)(1)(C).

Use this area to certify that the taxpayer identification number you are giving the payor is correct and that you are not subject to backup withholding.

Backup Withholding - You are subject to backup withholding if:

(1) You fail to furnish your taxpayer identification number to the payor; OR
(2) The Internal Revenue Service (IRS) notifies the payor that you furnished an incorrect taxpayer identification number; OR
(3) You are notified that you are subject to backup withholding [under Section 3406(a)(1)(C)]; OR
(4) For an interest or dividend account opened after December 31, 1983, you fail to certify to the payor that you are not subject to backup withholding under (3) above, or fail to certify your taxpayer identification number.

Payees Exempt From Backup Withholding - Certain payees, such as corporations, government agencies, etc. may be exempt from backup withholding.

What Number to Give the Payor - Give the social security number or employer identification number of the record owner of the account. If the account belongs to you as an individual, give your social security number. If the account is owned by a corporation, give the employer identification number of the corporation.

Obtaining a Number - If you don't have a taxpayer identification number or you don't know your number, obtain **Form SS-5**, Application for a Social Security Number Card, or **Form SS-4**, Application for Employer Identification Number, at the local office of the Social Security Administration or the Internal Revenue Service and apply for a number. Write “applied for” in place of your number. When you get a number, submit a new Form W-9 to the payor.

AGREEMENTS AND REPRESENTATIONS

It is hereby represented that the answers and statements on the application(s) and any Supplements required are complete, true and correctly recorded. Information not recorded on the application(s) and any Supplements will not be treated as known to the Company. A copy of the application(s) and any Supplements shall be a part of the policy, and it is agreed that the policy and copy of the application(s) and any Supplements constitute the entire contract. No changes will be made unless the owner agrees and the change is authorized in writing by an officer of the Company.

If a Conditional Life Insurance Agreement was delivered in consideration of the payment of the first premium and is in effect, its terms will apply. Otherwise the policy will take effect and coverage will begin on the issue date specified in the policy if the full first premium is paid, the Proposed Insured(s) is (are) living, and the answers and statements in the application(s) and any Supplements continue to be complete and true at the time of delivery of the policy.

Under penalties of perjury, I certify that (1) the social security or federal tax identification number shown on page 1 of this application for me as the owner of this policy is my correct taxpayer identification number, AND (2) I am a U.S. person (including a U.S. resident alien), AND (3) I am not subject to backup withholding because (a) I am exempt from backup withholding, or (b) I have not been notified by the IRS that I am subject to backup withholding as a result of failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding. NOTE: You must cross out item 3 in the above certification if you have been notified by the IRS that you are currently subject to backup withholding. The IRS does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

IMPORTANT INFORMATION ABOUT THE USA PATRIOT ACT

To help fight the funding of terrorism and money-laundering activities, the U.S. government has passed the USA PATRIOT Act, which requires financial institutions to obtain, verify and record information that identifies persons who engage in certain transactions with or through a financial institution, including insurance companies. This means that the Company will need to verify the **name, residential or street address (no P.O. Boxes), date of birth and social security number, drivers license and/or other identification information of all policy owners as may be required by law.**

AUTHORIZATION AND ACKNOWLEDGMENT

This authorization complies with the HIPAA Privacy Rule. I understand that if I refuse to sign this authorization, the Company may not be able to process my application for life insurance. I acknowledge that I have the right to request and receive a copy of this authorization.

Personal Health Information

I authorize any physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, health care provider, health plan, insurer, and/or any other entity subject to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) that has provided treatment, service, payment, or coverage to me within the past 10 years to disclose my entire medical record and any other protected health information concerning me to the Company, its agents, employees, representatives, insurance support organizations, and reinsurers ("the Company"). Protected health information includes but is not limited to: hospital records, treatment records/office notes, consultation reports, workers' compensation information, diagnosis, prescriptions, and test results. It also includes information concerning the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases, and information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, health care provider, health plan, insurer, and/or other entity subject to HIPAA to release and disclose such information without restriction.

I understand that, unless prohibited by state and/or federal law, the protected health information is to be disclosed under this authorization so that the Company may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have, have applied for, or may in the future apply for with the Company. I understand any information disclosed under this authorization may no longer be covered by federal rules governing privacy and confidentiality of health information and may be subject to re-disclosure.

Personal Private Information

I understand that an investigative consumer report may be prepared in connection with this application. I authorize any consumer reporting organization or employer having non-medical information about me to release such information to the Company, its reinsurers, or its authorized representatives. I authorize the Company to prepare an investigative consumer report. I understand that I may request to be personally interviewed if an investigative consumer report is prepared in connection with this application and not to have personal information disclosed for marketing purposes. Any information obtained will not be released by the Company, its reinsurers, or representatives to any person or organization except to reinsuring companies, the Medical Information Bureau, or other persons or organizations performing business or legal services in connection with my application, claim, as may be permitted or required by law, or as I may further authorize.

Limitations, Revocation and Rights

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization at any time. The request for revocation must be in writing and sent to the attention of the Underwriting Department of the Company. I understand that a revocation is not effective to the extent that the Company has already relied on this authorization or to the extent that the Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. Such revocation shall not apply to any use or disclosure of my protected health information specifically allowed without authorization by HIPAA and no action relating to this authorization shall be construed as creating any restriction on the uses that HIPAA allows without my authorization.

SIGNATURES

I have reviewed and understand the information contained above in the "Taxpayer Identification", "Agreements and Representations", including reviewing the answers and statements on the application(s) and any Supplements for accuracy, "Important Information About the USA Patriot Act", and "Authorization and Acknowledgment" sections, and further acknowledge receipt of the Disclosure Notice to Proposed Insured.

I understand, acknowledge and agree that the Agent has no authority to make any promise, representation or waiver regarding coverage or the terms of the policy. I also understand, acknowledge and agree that the Agent has no authority to provide any legal or tax advice on behalf of the Company. If any such legal or tax advice has been given, I understand, acknowledge and agree it has been done without Company authority and has not been given on behalf of the Company. I understand, acknowledge and agree that I am responsible for obtaining independent legal or tax advice with respect to any such matters. I understand, acknowledge and agree that all premium payments after the first are to be provided directly to the Company and that the Agent has no authority to receive, transmit, sign, endorse, deposit or process any subsequent payments made on the policy.

Signed / Dated at _____
City, State

On _____
Date

X _____
Signature of Licensed Agent

_____
Parent/Guardian or Witness (if required)

X _____
Signature of Owner/Proposed Insured
(or signature of Insured's Personal Representative*)

X _____
Signature of Owner if other than Proposed Insured

_____
If Owner is a corporation, business firm or trust, give full name and an Authorized person must sign and provide title

*If you are the Proposed Insured's Personal Representative, describe the scope and/or basis of your authority to act on the Proposed Insured's behalf:

_____

_____

☐ AMERUS Life

AmerUs Life Insurance Company
Home Office: Des Moines, IA
Mailing Address:
P.O. Box 1555
Des Moines, IA 50306-1555
Fax: 1-800/531-0038

☐ INDIANAPOLIS LIFE
An AMERUS Company

Indianapolis Life Insurance Company
Home Office: Indianapolis, IN
Mailing Address:
P. O. Box 14590
Des Moines, IA 50306-3590
Fax: 1-888/329-1329

TeleApp Application for Life Insurance

Please check appropriate company. ONE BOX MUST BE CHECKED.
(In this application, "Company" refers to the insurance company whose name is checked above.)

PROPOSED INSURED

Name (First, Middle, Last) _____ Is Insured also the Owner? ☐ Yes ☐ No

Address _____ Gender ☐ M ☐ F Maiden Name _____

City _____ State _____ Zip _____ Marital Status ☐ Married ☐ Single ☐ Divorced or Separated ☐ Widow or Widower

U.S. Citizen? ☐ Yes ☐ No Permanent Resident? ☐ Yes ☐ No

Birth Date _____ Birth State _____ Social Security Number _____

Home Ph. (_____) _____ Bus. Ph. (_____) _____ Employer _____

Annual earned income $_____ Annual unearned income $_____ Net worth $_____

Driver's License # _____ State _____ Issue Date _____ Expiry Date _____

Or, if you do not have a driver's license, other government issued photo ID: Document Type _____

Document # _____ Where Issued _____ Issue Date _____ Expiry Date _____

Occupation _____ Duration of Employment _____

OWNER INFORMATION

OWNER (If different from Proposed Insured) ☐ Individual ☐ Business ☐ Trust (date of trust) _____

Name (Owner, Business or Trustee) _____ Address _____

Birth Date _____ City _____ State _____ Zip _____

If trust, name of trust _____

Relationship _____ Social Security # or Taxpayer ID # _____

Owner's or Trustee's personal driver's license # or other government issued photo ID document, or corporate license:

Document Type _____ Document # _____ Where Issued _____ Issue Date _____ Expiry Date _____

CONTINGENT OWNER _____

Driver's License # or other government issued photo ID document: Document Type _____ Document # _____

Where Issued _____ Issue Date _____ Expiry Date _____

Mail notices to ☐ Insured ☐ Owner ☐ Other (specify) _____

Other Notice Address _____ City _____ State _____ Zip _____

Tax Qualification Type

☐ Qualified Plan:
Type: ☐ Profit Sharing Plan
☐ 401(k)
☐ 412(i)
☐ Other Defined Benefit

☐ Non-Qualified Plan:
Type: ☐ Welfare Benefit Plan:
☐ single employer
☐ multiple employer
☐ VEBA
☐ Deferred Comp
☐ Split Dollar
☐ Executive Bonus
☐ Other _____

☐ Neither

BENEFICIARY INFORMATION

PRIMARY BENEFICIARY(IES) - Applies to primary insured only. (If trust, complete name and date of trust.)
(If necessary, use an additional page for additional details, **signature of owner & date.)**

Print Full Name	Birth Date	Relationship	Percentage	Social Security # or Taxpayer ID #

CONTINGENT BENEFICIARY(IES)

Print Full Name	Birth Date	Relationship	Percentage	Social Security # or Taxpayer ID #

POLICY INFORMATION

Plan Applied _____ Amt. of Ins. $ _____ ☐ Nonsmoker/Nontobacco ☐ Smoker/Tobacco

UL Death Benefit Option: ☐ Level ☐ Increasing ☐ Death Benefit Return of Premium Rider

Additional Coverage _____ Amt. of Ins. $_____ Premium $ _____

Additional Coverage _____ Amt. of Ins. $_____ Premium $ _____

Riders _____

Waiver Type_____ Other Riders (Type/Amount) _____

RIDERS (complete supplemental application)

AIR $_____ Spouse Rider $_____ Child Rider $_____

PREMIUM INFORMATION

Premium Direction / Interest Crediting Strategy: 1 Year Point-to-Point_____% 2 Year Point-to-Point_____% 1 Year Monthly Average_____%
1 Year Monthly Cap_____% 1 Year Average Multiple Index_____% 5 Year Fixed Term_____% 1 Year Fixed Term_____% _____%
Levelized Strategy Transfer ☐ Yes ☐ No
Whole Life APL (if applicable) ☐ Yes ☐ No Direct Recognition (if available) ☐ Yes ☐ No

Premium Planned Premium $ _____ Additional Premium (lump sum) $ _____

Billing Frequency ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ PAC (Complete Authorization) ☐ Other _____

☐ Govt. Allotment ☐ Group Bill Group Bill #_____

Has the premium for the policy applied for been given to the agent? ☐ Yes ☐ No Amount $_____

How Paid? ☐ Check ☐ Other (specify) _____

Policy Date (optional)_____ Other _____

Are you financing or refinancing a mortgage and/or a home equity loan or contemplating the use of any kind of mortgage financing strategy in connection with the purchase of or the payment of premiums on the life insurance policy? . . . . . ☐ Yes ☐ No
(If yes, please review and acknowledge by signing the Mortgage Financing Disclosure Statement.)

Will you borrow money to pay the premiums for this policy or have someone else pay these premiums for you, in return for you assigning part of or all of the policy values to someone else? ☐ Yes ☐ No (If yes, please review and acknowledge by signing the Premium Financing Applicant Acknowledgement and Disclosure Statement.)

INSURANCE IN FORCE ON PROPOSED INSURED

Are any life insurance or annuity contracts in force? . . . . . ☐ Yes ☐ No
If yes, complete section below. (Attach separate sheet if necessary)

Company	Amount	WP ?	Personal/Business	Year Issued	Replacing ?	Amount ADB

Will any annuity or life insurance presently or recently in force be replaced or changed by this policy applied for? . . . . . ☐ Yes ☐ No
Have you ever been declined, rated, or had coverage modified or withdrawn, or reinstatement declined by any insurance company? . . . ☐ Yes ☐ No
Within the last year, has any other life, health or long term care insurance been issued or applied for, or is any to be applied for? . . . . . ☐ Yes ☐ No
Do you intend to sell or transfer all or any portion of this policy to another person, any group of investors or other entity? . . . . . ☐ Yes ☐ No
Has the proposed insured ever had or been treated by a medical professional for diabetes, heart disease, cancer, alcoholism or drug abuse?
. . . . . ☐ Yes ☐ No

Give complete details of any **Yes** answers to the questions in this section. (If necessary, use an additional page for additional details, **signed by the applicant and dated.)**

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance may be guilty of a crime and subject to fines and confinement in prison, depending on state law.

TAXPAYER IDENTIFICATION

Instructions (Section references are to the Internal Revenue Code.)
Use this form to report the taxpayer identification number (TIN) of the **policy owner.**
Payors must generally withhold a specified percentage of taxable interest, dividend, and certain other payments if you fail to furnish payors with the correct taxpayer identification number (this is referred to as backup withholding). For most individual taxpayers, the taxpayer identification number is the social security number.
To prevent backup withholding on these payments, be sure to notify payors of the correct taxpayer identification number and properly certify that you are not subject to backup withholding under Section 3406(a)(1)(C).
Use this area to certify that the taxpayer identification number you are giving the payor is correct and that you are not subject to backup withholding.

Backup Withholding - You are subject to backup withholding if:
(1) You fail to furnish your taxpayer identification number to the payor; OR
(2) The Internal Revenue Service (IRS) notifies the payor that you furnished an incorrect taxpayer identification number; OR
(3) You are notified that you are subject to backup withholding [under Section 3406(a)(1)(C)]; OR
(4) For an interest or dividend account opened after December 31, 1983, you fail to certify to the payor that you are not subject to backup withholding under (3) above, or fail to certify your taxpayer identification number.

Payees Exempt From Backup Withholding - Certain payees, such as corporations, government agencies, etc. may be exempt from backup withholding.

What Number to Give the Payor - Give the social security number or employer identification number of the record owner of the account. If the account belongs to you as an individual, give your social security number. If the account is owned by a corporation, give the employer identification number of the corporation.

Obtaining a Number - If you don't have a taxpayer identification number or you don't know your number, obtain **Form SS-5,** Application for a Social Security Number Card, or **Form SS-4,** Application for Employer Identification Number, at the local office of the Social Security Administration or the Internal Revenue Service and apply for a number. Write "applied for" in place of your number. When you get a number, submit a new Form W-9 to the payor.

AGREEMENTS AND REPRESENTATIONS

It is hereby represented that the answers and statements on the application(s) and any Supplements required are complete, true and correctly recorded. Information not recorded on the application(s) and any Supplements will not be treated as known to the Company. A copy of the application(s) and any Supplements shall be a part of the policy, and it is agreed that the policy and copy of the application(s) and any Supplements constitute the entire contract. No changes will be made unless the owner agrees and the change is authorized in writing by an officer of the Company.

If a Conditional Life Insurance Agreement was delivered in consideration of the payment of the first premium and is in effect, its terms will apply. Otherwise the policy will take effect and coverage will begin on the issue date specified in the policy if the full first premium is paid, the Proposed Insured(s) is (are) living, and the answers and statements in the application(s) and any Supplements continue to be complete and true at the time of delivery of the policy.

Under penalties of perjury, I certify that (1) the social security or federal tax identification number shown on page 1 of this application for me as the owner of this policy is my correct taxpayer identification number, AND (2) I am a U.S. person (including a U.S. resident alien), AND (3) I am not subject to backup withholding because (a) I am exempt from backup withholding, or (b) I have not been notified by the IRS that I am subject to backup withholding as a result of failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding. NOTE: You must cross out item 3 in the above certification if you have been notified by the IRS that you are currently subject to backup withholding. The IRS does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

IMPORTANT INFORMATION ABOUT THE USA PATRIOT ACT

To help fight the funding of terrorism and money-laundering activities, the U.S. government has passed the USA PATRIOT Act, which requires financial institutions to obtain, verify and record information that identifies persons who engage in certain transactions with or through a financial institution, including insurance companies. This means that the Company will need to verify the **name, residential or street address (no P.O. Boxes), date of birth and social security number, drivers license and/or other identification information of all policy owners as may be required by law.**

AUTHORIZATION AND ACKNOWLEDGMENT

This authorization complies with the HIPAA Privacy Rule. I understand that if I refuse to sign this authorization, the Company may not be able to process my application for life insurance. I acknowledge that I have the right to request and receive a copy of this authorization.

Personal Health Information

I authorize any physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, health care provider, health plan, insurer, and/or any other entity subject to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) that has provided treatment, service, payment, or coverage to me within the past 10 years to disclose my entire medical record and any other protected health information concerning me to the Company, its agents, employees, representatives, insurance support organizations, and reinsurers ("the Company"). Protected health information includes but is not limited to: hospital records, treatment records/office notes, consultation reports, workers' compensation information, diagnosis, prescriptions, and test results. It also includes information concerning the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases, and information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By my signature, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, laboratory, pharmacy, medical facility, health care provider, health plan, insurer, and/or other entity subject to HIPAA to release and disclose such information without restriction.

I understand that, unless prohibited by state and/or federal law, the protected health information is to be disclosed under this authorization so that the Company may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have, have applied for, or may in the future apply for with the Company. I understand any information disclosed under this authorization may no longer be covered by federal rules governing privacy and confidentiality of health information and may be subject to re-disclosure.

Personal Private Information

I understand that an investigative consumer report may be prepared in connection with this application. I authorize any consumer reporting organization or employer having non-medical information about me to release such information to the Company, its reinsurers, or its authorized representatives. I authorize the Company to prepare an investigative consumer report. I understand that I may request to be personally interviewed if an investigative consumer report is prepared in connection with this application and not to have personal information disclosed for marketing purposes. Any information obtained will not be released by the Company, its reinsurers, or representatives to any person or organization except to reinsuring companies, the Medical Information Bureau, or other persons or organizations performing business or legal services in connection with my application, claim, as may be permitted or required by law, or as I may further authorize.

Limitations, Revocation and Rights

This authorization shall remain in force for 24 months following the date of my signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization at any time. The request for revocation must be in writing and sent to the attention of the Underwriting Department of the Company. I understand that a revocation is not effective to the extent that the Company has already relied on this authorization or to the extent that the Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. Such revocation shall not apply to any use or disclosure of my protected health information specifically allowed without authorization by HIPAA and no action relating to this authorization shall be construed as creating any restriction on the uses that HIPAA allows without my authorization.

SIGNATURES

I have reviewed and understand the information contained above in the "Taxpayer Identification", "Agreements and Representations", including reviewing the answers and statements on the application(s) and any Supplements for accuracy, "Important Information About the USA Patriot Act", and "Authorization and Acknowledgment" sections, and further acknowledge receipt of the Disclosure Notice to Proposed Insured.

I understand, acknowledge and agree that the Agent has no authority to make any promise, representation or waiver regarding coverage or the terms of the policy. I also understand, acknowledge and agree that the Agent has no authority to provide any legal or tax advice on behalf of the Company. If any such legal or tax advice has been given, I understand, acknowledge and agree it has been done without Company authority and has not been given on behalf of the Company. I understand, acknowledge and agree that I am responsible for obtaining independent legal or tax advice with respect to any such matters. I understand, acknowledge and agree that all premium payments after the first are to be provided directly to the Company and that the Agent has no authority to receive, transmit, sign, endorse, deposit or process any subsequent payments made on the policy.

Signed / Dated at _____
City, State

On _____
Date

X _____
Signature of Licensed Agent

_____
Parent/Guardian or Witness (if required)

X _____
Signature of Owner/Proposed Insured
(or signature of Insured's Personal Representative*)

X _____
Signature of Owner if other than Proposed Insured

_____
If Owner is a corporation, business firm or trust, give full name and an Authorized person must sign and provide title

*If you are the Proposed Insured's Personal Representative, describe the scope and/or basis of your authority to act on the Proposed Insured's behalf:

_____

_____

POLICY DATA PAGE

POLICY NUMBER: IL00000100 AMOUNT OF INSURANCE: $100,000
INSURED: JOHN DOE POLICY DATE: JULY 1, 2008

BENEFIT	AMOUNT AT ISSUE	*ANNUAL PREMIUM	EXPIRY DATE
INSURED: JOHN DOE ISSUE AGE: 35 SEX: M RATE CLASS: Non-Tobacco PREMIUM PAYMENT MODE: Annual CONVERSION EXPIRY DATE: July 1, 2018			
Term Life Insurance	$100,000	$148.00	JULY 1, 2068
INSURED: Children 15 days to 25 years			
Children's Insurance Rider	$ 20,000	$140.00	JULY 1, 2038

PREMIUMS ARE PAYABLE ANNUALLY OR AT SUCH INTERVALS AS WE PERMIT. A BILLING CHARGE IS ADDED TO EACH PREMIUM, OTHER THAN ANNUAL PREMIUMS. YOU WILL PAY MORE BILLING CHARGES IF YOU PAY PREMIUMS MORE OFTEN. PLEASE CONTACT THE COMPANY IF YOU HAVE QUESTIONS, OR IF YOU WOULD LIKE TO CHANGE HOW OFTEN YOU PAY PREMIUMS.

PREMIUMS SHOWN ON THIS PAGE AND THE FOLLOWING PAGE ASSUME ANNUAL PREMIUM PAYMENTS AND DO NOT REFLECT ANY BILLING CHARGES.

*If base policy premiums vary after the first ten policy years, they can be found on subsequent pages.